		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031468

Facility Name: MONTEBELLO HEALTHCARE CENTER

Address: 16TH & Keokuk (Number) Hamilton (City) 62341 (Zip Code)

County: HANCOCK

Telephone Number: (217) 847-3931 **Fax #** (217) 847-2049

IDPA ID Number: 752080781001

Date of Initial License for Current Owners: 08/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cathy Simeoni **Telephone Number:** (714) 596-7713, Ext 12

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Linda Holtzscheiter
(Title) Reimbursement Manager

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Cathy Simeoni, Manager - Healthcare Consulting
(Firm Name & Address) Kellogg & Andelson, Accountancy Corporation
16162 Beach Blvd, #308, Huntington Beach, CA 92647
(Telephone) (714) 596-7713, fax 596-7721 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,874	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,874	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,297	2,297	8
9	SNF/PED					9
10	ICF	22,927	9,319		32,246	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,927	9,319	2,297	34,543	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.90%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 139 and days of care provided 2,297

Medicare Intermediary AdminaStar, Illinois

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	119,780	12,273	9,059	141,112		141,112		141,112			1
2	Food Purchase		149,595		149,595		149,595		149,595			2
3	Housekeeping	81,683	14,218	748	96,649		96,649		96,649			3
4	Laundry	39,619	14,620		54,239		54,239		54,239			4
5	Heat and Other Utilities			74,164	74,164		74,164		74,164			5
6	Maintenance	29,690	20,873	18,452	69,015		69,015	368	69,383			6
7	Other (specify):*											7
8	**TOTAL General Services**	270,772	211,579	102,423	584,774		584,774	368	585,142			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	874,905	50,196	212,737	1,137,838		1,137,838		1,137,838			10
10a	Therapy	98,011	4,142	31,927	134,080		134,080		134,080			10a
11	Activities	43,897	5,518	6,276	55,691		55,691		55,691			11
12	Social Services	37,753		1,063	38,816		38,816		38,816			12
13	Nurse Aide Training											13
14	Program Transportation	3,657			3,657		3,657		3,657			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,058,223	59,856	259,803	1,377,882		1,377,882		1,377,882			16
	C. General Administration											
17	Administrative	60,584			60,584		60,584		60,584			17
18	Directors Fees											18
19	Professional Services			8,940	8,940		8,940	13,144	22,084			19
20	Dues, Fees, Subscriptions & Promotions			2,514	2,514		2,514	246	2,760			20
21	Clerical & General Office Expenses	95,737	7,071	95,302	198,110		198,110	54,364	252,474			21
22	Employee Benefits & Payroll Taxes			245,388	245,388		245,388		245,388			22
23	Inservice Training & Education			4,444	4,444		4,444		4,444			23
24	Travel and Seminar			9,278	9,278		9,278	2,209	11,487			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			73,104	73,104		73,104	1,412	74,516			26
27	Other (specify):*											27
28	**TOTAL General Administration**	156,321	7,071	438,970	602,362		602,362	71,375	673,737			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,485,316	278,506	801,196	2,565,018		2,565,018	71,743	2,636,761			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER #0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			142,506	142,506		142,506	13,403	155,909			30
31	Amortization of Pre-Op. & Org.			118,281	118,281		118,281		118,281			31
32	Interest			(21)	(21)		(21)	34,953	34,932			32
33	Real Estate Taxes			54,687	54,687		54,687		54,687			33
34	Rent-Facility & Grounds							50,125	50,125			34
35	Rent-Equipment & Vehicles			13,085	13,085		13,085		13,085			35
36	Other (specify):*											36
37	**TOTAL Ownership**			328,538	328,538		328,538	98,481	427,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,575	15,417	34,992		34,992		34,992			39
40	Barber and Beauty Shops			(240)	(240)		(240)	240				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,312	76,312		76,312		76,312			42
43	Other (specify):* see page 4.2			1,081	1,081		1,081	58,057	59,138			43
44	**TOTAL Special Cost Centers**		19,575	92,570	112,145		112,145	58,297	170,442			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,485,316	298,081	1,222,304	3,005,701		3,005,701	228,521	3,234,222			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,557)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(481)	21		28
29	Other-Attach Schedule	9,976			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (5,103)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	233,624	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 233,624		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 228,521		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
MONTEBELLO HEALTHCARE CENTER
ID# 0031468
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Sales Taxes	$ (1,923)	21	1
2	Small Balance Adj	4	21	2
3	Barber and Beauty	240	40	3
4	Depreciation Reconciliation	(21,702)	30	4
5	Misc. Receipts	(1,126)	21	5
6	Personal Purchases - Misc	(474)	21	6
7	Activity Program Receipts	(148)	21	7
8	**FAS 121 depreciation adjustment	35,105	30	8
9				9
10				10
11	**The facility re-valued their assets in 1999. We			11
12	have reported the historical costs of the assets			12
13	consistent with the prior years, and have ensured			13
14	that depreciation expense is reported on straight			14
15	line. This adjustment is necessary to reverse the			15
16	re-valuation of historical cost.			16
17				17
18				18
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85				85
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87				87
88				88
89				89
90	**Total**	9,976		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	368	0	0	0	0	0	0	0	0	0	368	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	368	0	0	0	0	0	0	0	0	0	368	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,144	0	0	0	0	0	0	0	0	0	13,144	19
20	Fees, Subscriptions & Promotions	0	246	0	0	0	0	0	0	0	0	0	246	20
21	Clerical & General Office Expenses	(18,746)	73,110	0	0	0	0	0	0	0	0	0	54,364	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,209	0	0	0	0	0	0	0	0	0	2,209	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,412	0	0	0	0	0	0	0	0	0	1,412	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(18,746)	90,121	0	0	0	0	0	0	0	0	0	71,375	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,746)	90,489	0	0	0	0	0	0	0	0	0	71,743	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,403	0	0	0	0	0	0	0	0	0	0	13,403	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	34,953	0	0	0	0	0	0	0	0	0	34,953	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	50,125	0	0	0	0	0	0	0	0	0	50,125	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	13,403	85,078	0	0	0	0	0	0	0	0	0	98,481	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	240	0	0	0	0	0	0	0	0	0	0	240	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	58,057	0	0	0	0	0	0	0	0	0	58,057	43
44	**TOTAL Special Cost Centers**	240	58,057	0	0	0	0	0	0	0	0	0	58,297	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(5,103)	233,624	0	0	0	0	0	0	0	0	0	228,521	45

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Post Acute Network	100.00%	$	$	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	368	368	2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	13,144	13,144	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	246	246	4
5	V	21	Clerical and General Office Exp		Mariner Post Acute Network	100.00%	73,110	73,110	5
6	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	2,209	2,209	6
7	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	1,412	1,412	7
8	V	32	Interest Expense		Mariner Post Acute Network	100.00%	34,953	34,953	8
9	V	34	Rental & Leasing		Mariner Post Acute Network	100.00%	50,125	50,125	9
10	V	43	Other Expenses		Mariner Post Acute Network	100.00%	58,057	58,057	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 233,624	$ * 233,624	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Post Acute Network
Street Address: One Ravine Dr., Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: (770) 379-8203
Fax Number: (770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			$ 212,153	$		$	1
2	6	Repairs and Maintenance	Facility Costs			1,115,193			368	2
3	19	Professional Services	Facility Costs			19,156,199			13,144	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			352,775			246	4
5	21	Clerical and General Office Exp	Facility Costs			51,126,150			73,110	5
6	24	Travel and Seminar	Facility Costs			5,661,045			2,209	6
7	26	Insurance Premium	Facility Costs			9,082,939			1,412	7
8	32	Interest Expense	Facility Costs			31,744,386			34,953	8
9	34	Rental & Leasing	Facility Costs			60,829,914			50,125	9
10	43	Other Expenses	Facility Costs			8,511,848			58,057	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 187,792,602	$		$ 233,624	25

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Home Office Allocation										34,953	7
8												8
9	TOTAL Facility Related						$	$			$ 34,953	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 34,953	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	59,983	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	52,420	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,563)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	62,250	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	54,687	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	50,150	8
	1996	53,765	9
	1997	52,470	10
	1998	55,224	11
	1999	52,420	12

2000 REAL ESTATE ACCRUAL: 62,250

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	305,550	1993	$ 43,747	1
2					2
3	TOTALS	305,550		$ 43,747	3

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	139		1993	1974	$ 2,954,163	$ 109,742	35	$ 84,405	$ (25,337)	$ 591,259	4
5					46,664	1,167	20	2,333	1,166	16,344	5
6											6
7											7
8											8
	Improvement Type**										
9	INTERIOR BUILDING IMPROVEMENTS			1995	8,889		20	444	444	3,439	9
10	A/C UNITS			1996	2,775		20	139	139	753	10
11	WANDER GUARD SYSTEM			1996	887		20	44	44	239	11
12	SPRINKLER REPAIR			1997	2,239		20	112	112	541	12
13	SPRINKLER REPAIR			1997	2,317	116	20	116		447	13
14	CARPET IN LOBBY			1997	1,890	95	20	95		311	14
15	NURSES STATION			1997	2,363		20	118	118	550	15
16	A/C SYSTEMS			1997	8,325		20	416	416	1,852	16
17	NURSE STATION			1997	2,613		20	131	131	574	17
18	A/C			1997	2,969		20	148	148	541	18
19	LIGHT FIXTURES			1997	1,002		20	50	50	183	19
20	SPRINKLER REPAIR			1997	797		20	40	40	196	20
21	EXTERIOR SIGNS			1998	663	11	20	22	11	66	21
22	HEATING, VENTILATION & A/C			1998	2,643	37	20	77	40	231	22
23	HEATING, VENTILATION & A/C			1998	4,070	39	20	85	46	255	23
24	HEATING, VENTILATION & A/C			1998	6,800	51	20	113	62	339	24
25	PHONE SYSTEM			1998	1,338		20	61	61	183	25
26	NURSE STATION			1997	1,925		20	96	96	363	26
27	ADJUSTMENT 1998					(35)			35		27
28	WATER HEATER			1999	3,092	309	10	309	(0)	412	28
29	WATER PIPE HOOK-UP			1999	256	26	10	26	0	32	29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 3,058,680	$ 111,558		$ 89,380	$ (22,178)	$ 619,110	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 628,532	$ 72,101	$ 66,374	$ (5,727)	10	$ 353,627	37
38	Current Year Purchases	6,302	155	155		12	155	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 634,834	$ 72,256	$ 66,529	$ (5,727)		$ 353,782	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,737,261	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 183,814	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 155,909	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (27,905)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 972,892	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Overhead allocation	$ 636	$ 32	$ 146	52
53	Overhead allocation	1,136	57	232	53
54	Overhead allocation	2,127	106	362	54
55	Overhead allocation	360	18	58	55
56					56
57	TOTALS	$ 4,259	$ 213	$ 798	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 13,085 Description: Vehicle $11,803 Non-Medical Equipment $1,282 See pg 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		1999 Ford	$ 983.58	$ 11,803	17
18					18
19					19
20					20
21	TOTAL		$ 983.58	$ 11,803	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 2,908	$	$ 2,908
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			335		335
9	TOTALS		$	$ 3,244	$	$ 3,244
10	SUM OF line 9, col. 1 and 2	(e)	$ 3,244			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ none

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	1455	hrs	$ 32,618		$	$ 51	1,455	$ 32,669	1
2	Licensed Speech and Language Development Therapist	10A	271	hrs	6,423				271	6,423	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	876	hrs	18,722		31,816	1,080	876	51,618	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts			15,264	19,575		34,839	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Audiologist	39					153			153	13
14	TOTAL				$ 57,763		$ 47,233	$ 20,706	2,602	$ 125,702	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,076	$	1
2	Cash-Patient Deposits	186,636		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	379,436		3
4	Supply Inventory (priced at)	17,431		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 584,579	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	256,002		13
14	Buildings, at Historical Cost	1,997,836		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	299,991		16
17	Accumulated Depreciation (book methods)	(454,476)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,330,870		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(299,032)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,131,191	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,715,770	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 268,967	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,097		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,976		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,250		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See page 17.1	187,750		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 652,040	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See page 17.1	1,481,947		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,481,947	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,133,987	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,581,783	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,715,770	$	48

***(See instructions.)**

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,323,012	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,323,012	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(258,531)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (258,531)	17
	B. Transfers (Itemize):		
18	**Intercompany Transfers**	517,302	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 517,302	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,581,783	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,357,059	1
2	Discounts and Allowances for all Levels	(771,621)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,585,438	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	560,501	6
7	Oxygen	19,158	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 579,659	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	240	16
17	Sale of Drugs	61,941	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,377	19
20	Radiology and X-Ray	714	20
21	Other Medical Services	15,642	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 97,922	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	1,126	28
28a	Miscellaneous see page 19.1	325	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,451	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,264,470	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	584,771	31
32	Health Care	1,377,882	32
33	General Administration	602,363	33
	B. Capital Expense		
34	Ownership	328,538	34
	C. Ancillary Expense		
35	Special Cost Centers	35,833	35
36	Provider Participation Fee	76,312	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,005,699	40
41	**Income before Income Taxes (line 30 minus line 40)****	258,771	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 258,771	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,163	2,297	$ 49,599	$ 21.59	1
2	Assistant Director of Nursing	1,474	1,565	29,349	18.75	2
3	Registered Nurses	4,996	5,306	86,422	16.29	3
4	Licensed Practical Nurses	13,309	14,136	179,435	12.69	4
5	Nurse Aides & Orderlies	56,444	59,951	516,738	8.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,026	4,276	95,434	22.32	7
8	Rehab/Therapy Aides	296	314	5,477	17.44	8
9	Activity Director	2,001	2,125	20,811	9.79	9
10	Activity Assistants	3,841	4,080	23,245	5.70	10
11	Social Service Workers	3,084	3,276	34,739	10.60	11
12	Dietician					12
13	Food Service Supervisor	1,295	1,376	14,122	10.26	13
14	Head Cook	5,951	6,320	52,941	8.38	14
15	Cook Helpers/Assistants	8,109	8,613	55,460	6.44	15
16	Dishwashers					16
17	Maintenance Workers	2,372	2,519	29,041	11.53	17
18	Housekeepers	10,930	11,610	85,054	7.33	18
19	Laundry	6,360	6,756	42,378	6.27	19
20	Administrator	2,048	2,175	54,639	25.12	20
21	Assistant Administrator					21
22	Other Administrative	2,011	2,136	23,421	10.96	22
23	Office Manager					23
24	Clerical	4,201	4,462	47,535	10.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,119	1,188	12,443	10.47	31
32	Other Health Care(specify)					32
33	Other(specify)	1,672	1,776	27,033	15.22	33
34	TOTAL (lines 1 - 33)	137,702	146,257	$ 1,485,316 *	$ 10.16	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	183	$ 6,153	1-3	35
36	Medical Director	36	7,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	72	3,827	11-3	44
45	Social Service Consultant	72	1,063	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	363	$ 18,843		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	403	$ 13,524	10A-3	50
51	Licensed Practical Nurses	1,182	33,517	10A-3	51
52	Nurse Aides	7,978	145,065	10A-3	52
53	TOTAL (lines 50 - 52)	9,563	$ 192,106		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rebecca Bliss	Administrator	0	$ 60,584
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,584

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached - Exhibit 1	Legal Fees	$ 8,940
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,940

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,634
Unemployment Compensation Insurance	19,802
FICA Taxes	110,042
Employee Health Insurance	76,234
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	3,618
Employee Benefits	4,058
TOTAL (agree to Schedule V, line 22, col.8)	$ 245,388

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues	2,314
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,514

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
See Exhibit II	9,248
Seminar Expense	
Entertainment Expense	30
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,278

**See instructions.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **12.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,312**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **no** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **no**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.